

**EXHIBIT C**

# Estate of Geoffrey Cloud

## VITAL RECORDS CERTIFICATE

## DEATH TRANSCRIPT

## CERTIFICATE OF DEATH

156-01-045085

Certificate No.

NEW YORK CITY  
DEPARTMENT OF HEALTH  
2001 OCT -4 P 4:20  
DATE FILED1. NAME OF  
DECEASED Geoffrey W. Cloud  
(Type or print) (First Name) (Middle Name) (Last Name)

## MEDICAL CERTIFICATE OF DEATH (To be filled in by the O.C.M.E.)

2. PLACE OF DEATH NEW YORK CITY 2a. Name of hospital or other facility  
2b. BOROUGH  
Manhattan  
World Trade Center  
2c. Name of hospital or other facility  
First facility, street address  
1  DOA  Outpatient  
2  Emerg.  Inpatient2d. DATE OF  
CURRENT ADMISSION

Month Day Year

3. DATE AND HOUR OF DEATH OR FOUND DEAD 3a. (Month) (Day) (Year) 3b. HOUR 4. SEX  
September 11, 2001 12: AM  
2  PM MALE

5. APPROXIMATE AGE

36 Years

6. DEATH WAS CAUSED BY: Enter only one cause per line  
INTERVAL BETWEEN  
ONSET AND DEATHP a. Immediate cause Physical injuries, (Body Not Found)  
A b. Due to or as a consequence of  
R c. Due to or as a consequence ofT 7. Other significant conditions, contributing to death but not resulting in the underlying cause given in part 1  
1.  Other  
R 2.  Contributed  
A 3.  Resulted  
P 4.  Caused  
T 5.  Was a  
C 6.  Resulted  
S 7.  Contributed  
E 8.  Resulted  
L 9.  Caused  
D 10.  Contributed  
M 11.  Resulted  
H 12.  Caused  
N 13.  Contributed  
O 14.  Resulted  
P 15.  Caused  
T 16.  Contributed  
C 17.  Resulted  
E 18.  Caused  
L 19.  Contributed  
M 20.  Resulted  
H 21.  Caused  
N 22.  Contributed  
O 23.  Resulted  
P 24.  Caused  
T 25.  Contributed  
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T 655.  Contributed  
C 656.  Resulted  
E 657.  Caused  
L 658.  Contributed  
M 659.  Resulted  
H 660.  Caused

# Estate of Robert William Hamilton



# Estate of Donald W. Jones

## DEATH TRANSCRIPT

## CERTIFICATE OF DEATH

156-01-049952

Certificate No.

NEW YORK CITY  
DEPARTMENT OF HEALTH

2001 OCT 26 P 3:03

DATE FILED

1. NAME OF  
DECEASED Donald W. Jones  
(Type or print) (First Name) (Middle Name) (Last Name)

## MEDICAL CERTIFICATE OF DEATH (To be filled in by the O.C.M.E.)

2 PLACE OF DEATH	NEW YORK CITY 2a. BOROUGH Manhattan	2b Name of hospital or other facility if not facility, street address World Trade Center	2c If in Hospital or Other Facility 1 <input type="checkbox"/> DOA <input type="checkbox"/> Outpatient 2 <input type="checkbox"/> Emerg. 4 <input type="checkbox"/> Inpatient	2d If inpatient, date of current admission Month Day Year
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3. DATE AND HOUR OF DEATH OR FOUND DEAD	3a. (Month) (Day) (Year) September 11, 2001	3b. Hour <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM	4. SEX MALE	5. APPROXIMATE AGE 43 Years
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6. DEATH WAS CAUSED BY:	Enter only one cause per line			INTERVAL BETWEEN ONSET AND DEATH
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P A R T 1	a. Immediate cause Physical Injuries. (Body Not Found)	b. Due to or as a consequence of	c. Due to or as a consequence of	d. Other significant conditions contributing to death but not resulting in the underlying cause given in part 1
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PART 2		7a. INJURY: DATE (Month) (Day) (Year) September 11, 2001	7b. Time <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM	7c. AT WORK 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	7d. PLACE OF INJURY- At home, Farm, Street, etc. Office Building
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7f. HOW INJURY OCCURRED		Office Worker Killed in World Trade Center Disaster			
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8. Manner of Death <input type="checkbox"/> Pending Further Study <input type="checkbox"/> Natural <input type="checkbox"/> Accident	<input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Suicide <input type="checkbox"/> Undetermined	9. Autopsy <input type="checkbox"/> Yes <input type="checkbox"/> No Autopsy Pursuant to Law <input checked="" type="checkbox"/> No Autopsy	10. On the basis of examination and/or investigation. In my opinion, death occurred due to the causes and manner as stated. Certifier Signature: <i>Charles S. Hirsch</i> M.D. Date: October 25, 2001 Name (Print): Charles S. Hirsch, M.D.		
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11. M.E. Case No. DX0100062	12a. Date Pronounced Dead (Month) (Day) (Year) (if different from 3a)	12b. Time <input type="checkbox"/> AM. <input type="checkbox"/> PM
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PERSONAL PARTICULARS (To be filled in by Funeral Director, or in case of City Burial, by O.C.M.E.)		13. Usual Residence a. State PA b. County Bucks 13c. City, Town, or Location Fairless Hills 13d. Street & House No. 517 Fairhurst Road Zip Apt. No 19030 13e. Inside City Limits of 7c <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
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14. Served in U.S. Armed Forces No Yes Specify Years <input checked="" type="checkbox"/> From To	15. Marital Status (Check One) <input type="checkbox"/> Never married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Married or separated <input type="checkbox"/> Divorced	16. Name of Surviving Spouse (If wife, give maiden name) Susan Ann Burns
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17. Date of Birth of Decedent 08/27/58	18. Age at last birthday 43	if under 1 year mos days	if less than 1 day hours mins	19. Social Security No. 160-52-7710
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20a. Usual Occupation Bond Trader	20b. Kind of business or industry Securities		
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21. Birthplace (City & State or Foreign Country) Bristol Bucks County, PA	22. Education (Specify only highest grade completed) Elementary/Secondary (0-12)	23. Other name(s) by which decedent was known Donny
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24. NAME OF FATHER OF DECEASED John R. Jones	25. MAIDEN NAME OF MOTHER OF DECEASED Audrey Carango
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26a. NAME OF INFORMANT Susan Jones	26b. RELATIONSHIP TO DECEASED Wife	26c. ADDRESS (CITY) (STATE) (ZIP) 517 Fairhurst Rd, Fairless Hills, PA 19030
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27a. NAME OF CEMETERY OR CREMATORIAL	27b. LOCATION (City, Town, State and Country)	27c. DATE OF BURIAL OR CREMATION
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28a. FUNERAL ESTABLISHMENT	28b. ADDRESS
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VR16(1/94) (9/01) VITAL RECORDS DEPARTMENT OF HEALTH THE CITY OF NEW YORK

This is to certify that the foregoing is a true copy of a record on file in the Department of Health. The Department of Health does not certify to the truth of the statements made thereon, as no inquiry as to the facts has been provided by law.

Do not accept this transcript unless it bears the security features listed on back. Reproduction or alteration of this transcript is prohibited by §3.21 of the New York City Health Code if the purpose is the evasion or violation of any provision of the Health Code or any other law.  
DATE ISSUED OCT. 26, 2001

DOCUMENT No. F377110

*Steven P. Schwartz*

Steven P. Schwartz, Ph.D., City Registrar



# Estate of Martin Paul Michelstein

Y260787

APPROVED FOR FILING BY COMM'R OF HEALTH AUG 13 2002

Deputy City Registrar  
E. Timbers

## AMENDED CERTIFICATE OF DEATH

Certificate No. 156-01-050153

ORIGINAL FILED

Oct 27, 2001

DATE FILED

1. NAME OF DECEASED	Martin	Paul	Michelstein
(Type or print)	(First Name)	(Middle Name)	(Last Name)

## MEDICAL CERTIFICATE OF DEATH (To be filled in by the O.C.M.E.)

2. PLACE OF DEATH	NEW YORK CITY 2a. BOROUGH Manhattan	2b. Name of hospital or other facility if not facility, street address World Trade Center	2c. If in Hospital or Other Facility 1 <input type="checkbox"/> DOA 3 <input type="checkbox"/> Outpatient 2 <input type="checkbox"/> Emerg. 4 <input type="checkbox"/> Inpatient	2d. If inpatient, date of current admission Month Day Year	
3. DATE AND HOUR OF DEATH OR FOUND DEAD	3a. (Month) (Day) (Year) September 11, 2001		3b. Hour <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM	4. SEX MALE	5. APPROXIMATE AGE 57 Years

6. DEATH WAS CAUSED BY:  P A R T 1		Enter only one cause per line		INTERVAL BETWEEN ONSET AND DEATH
a. Immediate cause	Blunt Trauma.			
b. Due to or as a consequence of				
c. Due to or as a consequence of				

PART 2		d. Other significant conditions contributing to death but not resulting in the underlying cause given in part 1			
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7a. INJURY: DATE (Month) (Day) (Year) September 11, 2001	7b. TIME <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM	7c. AT WORK 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	7d. PLACE OF INJURY- At home, Farm, Street, etc. Office Building 7e. LOCATION World Trade Center		
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7f. HOW INJURY OCCURRED		Visitor Killed in World Trade Center Disaster			
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8. Manner of Death <input type="checkbox"/> Pending Further Study <input type="checkbox"/> Natural <input type="checkbox"/> Accident	<input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Suicide <input type="checkbox"/> Undetermined	9. Autopsy <input type="checkbox"/> Yes <input type="checkbox"/> No Autopsy <input type="checkbox"/> Pursuant to Law <input checked="" type="checkbox"/> No Autopsy	10. On the basis of examination and/or investigation, in my opinion, death occurred due to the causes and manner as stated: Certifier Signature: <i>Stephanie Fiedl</i> M.D. Date: November 16, 2001 Name (Print) Freda Frederic, M.D. Medical Examiner		
11. M.E. Case No. DMC106886	12a. Date Pronounced Dead (Month) (Day) (Yr) (if different from 3a)	12b. Time <input type="checkbox"/> AM. <input type="checkbox"/> PM.			

## PERSONAL PARTICULARS (To be filled in by Funeral Director, or in case of City Burial, by O.C.M.E.)

13. Usual Residence a. State NJ	13b. County Morris	13c. City, Town, or Location Morristown	13d. Street & House No. 11 Robertson Court	Zip 07960	Apt. No	13e. Inside City Limits of 13c <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
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14. Served in U.S. Armed Forces No <input type="checkbox"/> Yes <input type="checkbox"/> Specify Years <input type="checkbox"/> From 0462 To	15. Marital Status (Check One) <input type="checkbox"/> Never married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Married or separated <input type="checkbox"/> Divorced	16. Name of Surviving Spouse (If wife, give maiden name) Anne McNeil
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17. Date of Birth of Decedent 04/16/1944	18. Age at last birthday 57	19. Social Security No. 070-34-4692
	if under 1 year mos. days	if less than 1 day hours mins

20a. Usual Occupation Insurance Executive	20b. Kind of business or industry Insurance	
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21. Birthplace (City & State or Foreign Country) Manhattan, New York	22. Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	23. Other name(s) by which decedent was known
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24. NAME OF FATHER OF DECEASED Morris Michelstein	25. MAIDEN NAME OF MOTHER OF DECEASED Rose Shadowitz
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26a. NAME OF INFORMANT Anne C. McNeil	26b. RELATIONSHIP TO DECEASED Wife	26c. ADDRESS 11 Robertson Court, Morristown, NJ 07960
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27a. NAME OF CEMETERY OR CREMATORIAL St. Bernard's Cemetery	27b. LOCATION (City, Town, State and Country) Concord, Mass.	27c. DATE OF BURIAL OR CREMATION June 22, 2002
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28a. FUNERAL ESTABLISHMENT Joseph Dee & Son Funeral Service	28b. ADDRESS 33 Bedford Street Concord, Mass. 01742
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VR16(1/94) (9/01) VITAL RECORDS DEPARTMENT OF HEALTH THE CITY OF NEW YORK

Gretchen Van Wye  
Gretchen Van Wye, Ph.D., City Registrar as of 9/1/18

This is to certify that the foregoing is a true copy of a record on file in the Department of Health and Mental Hygiene. The Department of Health and Mental Hygiene does not certify to the truth of the statements made thereon, as no inquiry as to the facts has been provided by law.

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July 29, 2020

Steven P. Schwartz  
Steven P. Schwartz, Ph.D., City Registrar

R 0 4 4 0 8 4 0 1



# Estate of Walwyn Wellington Stuart, Jr.

Y280658

APPROVED FOR FILING BY COMM'R OF HEALTH NOV 30 2004

S. Barnard

## AMENDED CERTIFICATE OF DEATH

Certificate No. 156-01-062956

ORIGINAL FILED

Apr 11, 2001  
DATE FILED

1. NAME OF DECEASED (Type or print)	Walwyn	Wellington	Stuart, Jr. (Last Name)
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## MEDICAL CERTIFICATE OF DEATH (To be filled in by the O.C.M.E.)

2 PLACE OF DEATH	NEW YORK CITY 2a BOROUGH Manhattan	2b. Name of hospital or other facility if not facility, street address World Trade Center	2c If in Hospital or Other Facility 1 <input type="checkbox"/> DOA 3 <input type="checkbox"/> Outpatient 2 <input type="checkbox"/> Emerg 4 <input type="checkbox"/> Inpatient	2d If inpatient, date of current admission Month Day Year
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3 DATE AND HOUR OF DEATH OR FOUND DEAD	3a (Month) (Day) (Year) September 11, 2001	3b Hour <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM	4 SEX MALE	5 APPROXIMATE AGE 28 Years
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6 DEATH WAS CAUSED BY:	Enter only one cause per line	INTERVAL BETWEEN CNSET AND DEATH
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P A R T 1	a Immediate cause Blunt Trauma	INTERVAL BETWEEN CNSET AND DEATH
b Due to or as a consequence of		
c Due to or as a consequence of		

PART 2	d Other significant conditions contributing to death but not resulting in the underlying cause given in part 1
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7a. INJURY DATE (Month) (Day) (Year) September 11, 2001	7b TIME <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM	7c AT WORK 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	7d PLACE OF INJURY- At home, Farm, Street, etc Office Building
---	--	--	---

7e LOCATION World Trade Center
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7f HOW INJURY OCCURRED Port Authority Police Officer Responding to World Trade Center Disaster
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8 Manner of Death <input type="checkbox"/> Pending Further Study <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Natural <input type="checkbox"/> Suicide <input type="checkbox"/> Accident <input type="checkbox"/> Undetermined	9 Autopsy <input type="checkbox"/> Yes <input type="checkbox"/> No Autopsy <input type="checkbox"/> Pursuant to Law <input checked="" type="checkbox"/> No Autopsy	10 On the basis of examination and/or investigation In my opinion, death occurred due to the causes and manner as stated Certifier Signature: <u>Mark Horwitz</u> M.D. <i>for</i> Date: October 28, 2004
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11 M E Case No DM0116904	12a. Date Pronounced Dead (Month) (Day) (Yr) (if different from 3a)	12b Time <input type="checkbox"/> AM <input type="checkbox"/> PM	Name (Print) Karen Turi, M.D. Medical Examiner
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## PERSONAL PARTICULARS (To be filled in by Funeral Director, or in case of City Burial, by O C M.E.)

13 Usual Residence a State NY	13b County Nassau	13c City, Town, or Location Valley Stream	13d Street & House No 130 Broadway	Zip 11580	Apt No	13e Inside City Limits of 13c <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
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14 Served in U S Armed Forces No Yes Specify Years <input checked="" type="checkbox"/> From To	15 Marital Status (Check One) <input type="checkbox"/> Never married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Married or separated <input type="checkbox"/> Divorced	16 Name of Surviving Spouse (if wife, give maiden name) Thelma Lewis
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17 Date of Birth of Decedent 02/13/1973	18 Age at last birthday 28	If under 1 year mos days	If less than 1 day hours mins	19 Social Security No 117-56-5953
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20a Usual Occupation Police Officer	20b Kind of business or industry Public Safety		
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21 Birthplace (City & State or Foreign Country) Brooklyn, NY	22 Education (Specify only highest grade completed) Elementary/Secondary (0-12)	23 Other name(s) by which decedent was known 4
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24 NAME OF FATHER OF DECEASED Walwyn Stuart, Sr.	25 MAIDEN NAME OF MOTHER OF DECEASED Doris Campbell
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26a NAME OF INFORMANT Thelma C. Stuart	26b RELATIONSHIP TO DECEASED Wife	26c ADDRESS (CITY) (STATE) (ZIP) 130 Broadway, Valley Stream, NY 11580
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27a NAME OF CEMETERY OR CREMATORIAL Interim Disposition - OCME	27b LOCATION (City, Town, State and Country) 520 First Avenue, New York, NY 10016	27c DATE OF BURIAL OR CREMATION
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28a FUNERAL ESTABLISHMENT	28b ADDRESS Sister Janice, Ph.D., City Registrar as of 9/1/18	
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This is to certify that the foregoing is a true copy of a record on file in the Department of Health  
and Mental Hygiene, The City of New York, Health and Mental Hygiene Department, Bureau of Vital Statistics  
and that the statements made thereon, as no inquiry as to the facts has been provided by law.

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purpose is the evasion or violation of any provision of the Health Code or any other law.

Steven P. Schwartz



R 0 4 3 7 1 9 3 3

February 27, 2020



# Estate of Paul Arlan Tegtmeier

## VITAL RECORDS CERTIFICATE

## DEATH TRANSCRIPT

## RAISED SEAL

NEW YORK CITY  
DEPARTMENT OF HEALTH2001 NOV 16 A 9:46  
DATE FILED

## CERTIFICATE OF DEATH

156-01-054104

Certificate No.

1. NAME OF  
DECEASED

Paul

A.

Tegtmeier

(Type or print)

(First Name)

(Middle Name)

(Last Name)

## MEDICAL CERTIFICATE OF DEATH

(To be filled in by the O.C.M.E.)

2. PLACE OF DEATH	NEW YORK CITY 2a. BOROUGH Manhattan	2b. Name of hospital or other facility if not facility, street address World Trade Center	2c. If in Hospital or Other Facility 1 <input type="checkbox"/> DOA    3 <input type="checkbox"/> Outpatient 2 <input type="checkbox"/> Emerg.    4 <input type="checkbox"/> Inpatient	2d. If inpatient, date of current admission Month    Day    Year
-------------------------	---	---	--	---

3. DATE AND HOUR OF DEATH OR FOUND DEAD	3a. (Month) (Day) (Year) September 11, 2001	3b. Hour <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM	4. SEX MALE	5. APPROXIMATE AGE 41 Years
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6. DEATH WAS CAUSED BY: Enter only one cause per line				
P	a. Immediate cause    Physical Injuries. (Body Not Found)			
A	b. Due to or as a consequence of			
R	c. Due to or as a consequence of			
T				
1				

PART 2    d. Other significant conditions contributing to death but not resulting in the underlying cause given in part 1				
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7a. INJURY: DATE (Month) (Day) (Year) September 11, 2001	7b. TIME <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM	7c. AT WORK 1 <input checked="" type="checkbox"/> Yes    2 <input type="checkbox"/> No	7d. PLACE OF INJURY- At home, Farm, Street, etc. Office Building
--	--	---	---

7e. LOCATION World Trade Center
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7f. HOW INJURY OCCURRED    FireFighter Responding to World Trade Center Disaster
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8. Manner of Death <input type="checkbox"/> Pending Further Study <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Natural <input type="checkbox"/> Suicide <input type="checkbox"/> Accident <input type="checkbox"/> Undetermined	9. Autopsy <input type="checkbox"/> Yes <input type="checkbox"/> No Autopsy Pursuant to Law <input checked="" type="checkbox"/> No Autopsy	10. On the basis of examination and/or investigation, in my opinion, death occurred due to the causes and manner as stated: Certifier Signature: <u>Charles S. Hirsch</u> M.D. Date: November 15, 2001
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11. M.E. Case No. DX0102087	12a. Date Pronounced Dead (Month) (Day) (Yr) (If different from 3a)	12b. Time <input type="checkbox"/> AM <input type="checkbox"/> PM	Name: Charles S. Hirsch, M.D. (Print)    Chief Medical Examiner
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## PERSONAL PARTICULARS (To be filled in by Funeral Director, or in case of City Burial, by O.C.M.E.)

13. Usual Residence a. State NY	13b. County Dutchess	13c. City, Town, or Location Hyde Park	13d. Street & House No. 3 Thurston Lane	Zip 12538	Apt. No	13e. Inside City Limits of 7c <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
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14. Served in U.S. Armed Forces No    Yes    Specify Years <input checked="" type="checkbox"/> From <input type="checkbox"/> To	15. Marital Status (Check One) <input type="checkbox"/> Never married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Married or separated <input type="checkbox"/> Divorced	16. Name of Surviving Spouse (If wife, give maiden name) Catherine Greene
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17. Date of Birth (Month) (Day) (Year) of Decedent 03/24/60	18. Age at last birthday 41	if under 1 year mos.    days	if less than 1 day hours    mins	19. Social Security No. 092-54-6187
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20a. Usual Occupation Firefighter	20b. Kind of business or industry Public Safety
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21. Birthplace (City & State or Foreign Country) Poughkeepsie, NY	22. Education (Specify only highest grade completed) Elementary/Secondary (0-12)    College (1-4 or 5+) 4	23. Other name(s) by which decedent was known
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24. NAME OF FATHER OF DECEASED Richard Tegtmeier	25. MAIDEN NAME OF MOTHER OF DECEASED Tarkos
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26a. NAME OF INFORMANT Catherine M. Tegtmeier	26b. RELATIONSHIP TO DECEASED Wife	26c. ADDRESS (CITY) (STATE) (ZIP) 3 Thurston Lane, Hyde Park, NY 12538
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27a. NAME OF CEMETERY OR CREMATORIAL ESTABLISHMENT	27b. LOCATION (City, Town, State and Country)	27c. DATE OF BURIAL OR CREMATION
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28a. FUNERAL ESTABLISHMENT	28b. ADDRESS
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VR16(1/94) (9/01) VITAL RECORDS DEPARTMENT OF HEALTH THE CITY OF NEW YORK

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Steven P. Schwartz

Steven P. Schwartz, Ph.D., City Registrar

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DATE ISSUED NOV. 16, 2001

DOCUMENT No. F320869

